

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

10288
Do not use this space.

1. PLACE OF DEATH

(a) County BuchananRegistration District No. 85(b) Township St JosephPrimary Registration District No. 100Registered No. 369(c) City St Joseph(d) Street No. State Hospital for Insane No. 7 St.

(e) Length of residence in city or town where death occurred

yrs. mos. ds.

(f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 1810 gone

(Usual place of abode, if no street address, write county or city)

St. St Joseph, Mo.

(If not resident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

Dec. 7, 1881

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. min.

58324

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

Clerk

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Missouri

FATHER

13. NAME

Thomas N. Finch

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

North Carolina

MOTHER

15. MAIDEN NAME

Martha Spencer

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Illinois

17. INFORMANT (ADDRESS)

Hospital Records St Joseph, Mo

18. BURIAL, CREMATION, OR REMOVAL

PLACE

St. Joseph, Mo

DATE

Apr. 3, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS)

Heaton, Belal & Son 319 So 10th Lumber House

20. FILED

April 3, 1940St Joseph, Mo

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 31, 194022. I HEREBY CERTIFY, That I attended deceased from March 14, 1940, to March 31, 1940I last saw him alive on March 31, 1940 Death is saidto have occurred on the date stated above, at 5:20 P.M.

The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis

Date of onset

Indefinite34

Other contributory causes of importance:

Syphilis duration 25 yrs duration had had extensive treatment 'Aureo Dinitis'Name of operation NoneDate of ✓What test confirmed diagnosis? Clinical Lab Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? No Date of injury ✓, 19 ✓Where did injury occur? None (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury NoneNature of injury None24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed)

D.G. Miles

M. D.

(Address)

State Hospital No 2 St Joseph, Mo

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Wm. B. Summerfield

Licensed Embalmer No. 3007

P. O. Address 319 So. Di. Joseph St.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.